

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08044

8046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 3½ Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle May Last Bevins				4. DATE OF DEATH Month July Day 22 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1896	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Henry Smith				14. MOTHER'S MAIDEN NAME Irene Fields			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. None		17. INFORMANT Foster Smith Address Betterton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac insufficiency 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic valvular insufficiency DUE TO (c) Rheumatic fever							INTERVAL BETWEEN ONSET AND DEATH 1 hour 30 years 50 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) two cerebrovascular accidents 3 years apart, 1 acute.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Worton, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from 8-18 , 19 54 , to July 22 , 19 58 , that I last saw the deceased alive on July 21 , 19 58 , and that death occurred at 6:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Worton, Md.							
ACTUAL SIGNATURE Florence Deringer Joyce M.D.				DATE SIGNED 7/23/58			
PHYSICIAN'S NAME (Type) Florence Deringer Joyce				Worton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR Jul 24 '58	
				24b. REGISTRAR'S SIGNATURE W. J. Beach			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James A. Jones</i>		AGE <i>35</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Dec. 11, 1935</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>1234 Main St., Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart failure</i>		MANNER OF DEATH <i>Natural</i>		CERTIFICATE NO. <i>1234</i>		REGISTRATION NO. <i>5678</i>	
DATE OF BIRTH <i>Nov. 15, 1900</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John A. Jones</i>		SPOUSE'S RESIDENCE <i>1234 Main St., Baltimore, Md.</i>	
DATE OF DEATH <i>Dec. 11, 1935</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart failure</i>		MANNER OF DEATH <i>Natural</i>		CERTIFICATE NO. <i>1234</i>		REGISTRATION NO. <i>5678</i>	
DATE OF BIRTH <i>Nov. 15, 1900</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SPOUSE <i>John A. Jones</i>		SPOUSE'S RESIDENCE <i>1234 Main St., Baltimore, Md.</i>	

Two copies were made and sent to the following:

- 1 to the Registrar*
- 1 to the family*
- 1 to the physician*
- 1 to the coroner*

1/2/36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8047

CERTIFICATE OF DEATH

Reg. Dist. No. 08045

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Ann Co Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilbur Cannan</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Rock Hall MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel E. Cannan</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Higgins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>219-03-2648</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/25</u> , 19 <u>58</u> to <u>7/26</u> , 19 <u>58</u> that I last saw the deceased alive on <u>7/25</u> , 19 <u>58</u> , and that death occurred at <u>12:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, MD</u> DATE SIGNED <u>7/26/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>28/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>JUL 29 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. M. Gatewood</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1900	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JAN 20 1965		BALTIMORE, MD		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1965		JAN 20 1965		JAN 20 1965		JAN 20 1965	
ADDRESS OF DECEASED		ADDRESS OF PHYSICIAN		ADDRESS OF REGISTRAR		ADDRESS OF WITNESS	
1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.		1234 E. BALTIMORE ST.	
CITY		CITY		CITY		CITY	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		STATE		STATE		STATE	
MD		MD		MD		MD	
COUNTY		COUNTY		COUNTY		COUNTY	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
ZIP CODE		ZIP CODE		ZIP CODE		ZIP CODE	
21201		21201		21201		21201	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08048

CERTIFICATE OF DEATH

Reg. Dist. No.

8052

1. PLACE OF DEATH o. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First O. COLEMAN Middle COLEMAN Last		4. DATE OF DEATH JULY 7 1958 Month JULY Day 7 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28-1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PERRY OTHOSON		14. MOTHER'S MAIDEN NAME ANNIE HUTCHINSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT WALTER COLEMAN Address ROCK HALL, MD.			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Long Standing Rheumatic Mitralis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/5/58 , 19____, to 7/7/58 , 19____, that I last saw the deceased alive on 7/5/58 , 19____, and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William M. Hattwood M.D.		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 7/8/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 9	
22c. NAME OF CEMETERY OR CREMATORY TOWNSEND		22d. LOCATION (City, town, or county) (State) TOWNSEND DELAWARE	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Lane ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR JUL 16 '58 DATE	
24b. REGISTRAR'S SIGNATURE W. Beach			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8053

CERTIFICATE OF DEATH

08047

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First Everett Middle Rock Last				4. DATE OF DEATH July Month 12 Day 19 Year 58			
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1902	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kulley				14. MOTHER'S MAIDEN NAME Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John L. Everett--Rock Hall, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis of Ovary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 58 , to July 12 , 19 58 , that I last saw the deceased alive on July 12 , 19 58 , and that death occurred at 4:15 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbert C. Nitsch		M.D. Rock Hall		ADDRESS (Street, city or town, state) Rock Hall, Maryland		DATE SIGNED July 13/58	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		Rock Hall, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE Jul 17 '58		24b. REGISTRAR'S SIGNATURE Edgar Lane	

GRAND JURY BOARD

CERTIFICATE OF DEATH

MAINTAIN STATE DEPT. OF HEALTH - BATHING 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1234 5th Ave		Clerk		Heart Disease		Natural		12345		Yes	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		NOTED	
JAN 1 1855		NEW YORK		High School		Married		JAN 15 1900		JAN 15 1900	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE	
JAMES H. HARRIS		MARY H. HARRIS		Clerk		Homemaker		1234 5th Ave		1234 5th Ave	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S REGISTERED		MOTHER'S REGISTERED		FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.	
Natural		Natural		Yes		Yes		12345		67890	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S WITNESS		MOTHER'S WITNESS		FATHER'S ADDRESS		MOTHER'S ADDRESS	
JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		1234 5th Ave		1234 5th Ave	
FATHER'S DATE OF SIGNATURE		MOTHER'S DATE OF SIGNATURE		FATHER'S PLACE OF SIGNATURE		MOTHER'S PLACE OF SIGNATURE		FATHER'S CAUSE OF SIGNATURE		MOTHER'S CAUSE OF SIGNATURE	
JAN 15 1900		JAN 15 1900		NEW YORK		NEW YORK					
FATHER'S MANNER OF SIGNATURE		MOTHER'S MANNER OF SIGNATURE		FATHER'S REGISTERED		MOTHER'S REGISTERED		FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.	
Natural		Natural		Yes		Yes		12345		67890	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S WITNESS		MOTHER'S WITNESS		FATHER'S ADDRESS		MOTHER'S ADDRESS	
JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		1234 5th Ave		1234 5th Ave	
FATHER'S DATE OF SIGNATURE		MOTHER'S DATE OF SIGNATURE		FATHER'S PLACE OF SIGNATURE		MOTHER'S PLACE OF SIGNATURE		FATHER'S CAUSE OF SIGNATURE		MOTHER'S CAUSE OF SIGNATURE	
JAN 15 1900		JAN 15 1900		NEW YORK		NEW YORK					
FATHER'S MANNER OF SIGNATURE		MOTHER'S MANNER OF SIGNATURE		FATHER'S REGISTERED		MOTHER'S REGISTERED		FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.	
Natural		Natural		Yes		Yes		12345		67890	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08048

8048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X rural Worton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hosp</u>				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hallie</u> Middle <u>Maxwell</u> Last <u>Fogwell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1890</u> 68 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Andrew J. Toulson</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Sapp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0225</u>		17. INFORMANT <u>Mrs. Allan Blizzard</u>		Address <u>Worton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Cardiovascularrenal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Chestertown, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>7-12</u> , 19 <u>58</u> to <u>7-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-16</u> , 19 <u>58</u> , and that death occurred at <u>12:10p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. C. Dick</u> M.D.				ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>7-17-58</u>			
PHYSICIAN'S NAME (Type) <u>A. C. Dick</u>				<u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 18 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John A. Smith		45		Male		White		1918		Home	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF BIRTH		PLACE OF BIRTH	
Married		1915		Baltimore		Mary A. Smith		1873		Maryland	
PREVIOUS MARRIAGES		DATE		PLACE		NAME OF SPOUSE		DATE OF BIRTH		PLACE OF BIRTH	
None											
EDUCATION		SCHOOL		DEGREE		DATE		PLACE		NAME OF SCHOOL	
High School		Baltimore		Bachelor's		1910		Baltimore		Johns Hopkins University	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF BIRTH		PLACE OF BIRTH	
Physician		1910		Baltimore		Johns Hopkins Hospital		1873		Maryland	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
Heart Disease		1918		Baltimore		John A. Smith		1873		Maryland	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
Natural		1918		Baltimore		John A. Smith		1873		Maryland	
PLACE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
Home		1918		Baltimore		John A. Smith		1873		Maryland	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		1918		Baltimore		John A. Smith		1873		Maryland	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		1918		Baltimore		John A. Smith		1873		Maryland	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF BIRTH		PLACE OF BIRTH	
John A. Smith		1918		Baltimore		John A. Smith		1873		Maryland	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CORONER CALLED - BUT NOT AVAILABLE
8054
CERTIFICATE OF DEATH

08049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.J. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREGG NECK, RURAL GALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLINGSWOOD 67X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER First WOOLVERTON Middle FRAZEE SR. 4. DATE OF DEATH JULY Month 6 Day 19 Year 58							
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1909	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISTRICT PLANT MANAGER				10b. KIND OF BUSINESS OR INDUSTRY LAMP DEPT.		11. BIRTHPLACE (State or foreign country) CAMDEN, N.J.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WALTER W. FRAZEE				14. MOTHER'S MAIDEN NAME MABEL C. BENNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT AGNES H. FRAZEE		Address 632 LEES AVE. COLLINGSWOOD, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 20 min unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 July , 19 58 , to 6 July , 19 58 , that I last saw the deceased alive on 6 July , 19 58 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 6 July 58							
ACTUAL SIGNATURE Wallace O'Brien M.D.							
PHYSICIAN'S NAME (Type) WALLACE O'BENSHAIN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		7/9/58		HARLEIGH CEM.		CAMDEN N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hellous				ADDRESS Belmont, Md.		24a. REC'D BY REGISTRAR Jul 8 58	
						24b. REGISTRAR'S SIGNATURE W. J. Smith	

18

10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8055

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G232 8-5-58 et

Reg. Dist. No.

08050

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New Jersey b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Runnemede 67x-3 d. STREET ADDRESS 120 Singley Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Roy Last Harms		4. DATE OF DEATH Month July Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17-1906
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 26 Hours 19 Min. 58	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick-layer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Harms		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 165-05-9346	
17. INFORMANT Mrs. Harms--Runnemede, New Jersey		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) occlusion of Cerebral Vessel (c) occlusion of Cerebral Vessel DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Norbert C. Nitsch		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) NORBERT C. NITSCH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 29	
22c. NAME OF CEMETERY OR CREMATORY Locustwood		22d. LOCATION (City, town, or county) (State) Pennsauken, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR JUL 30 '58		24b. REGISTRAR'S SIGNATURE W. L. Search	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		DIAGNOSIS		TREATMENT		HISTORY		FAMILY HISTORY	
EDUCATION		OCCUPATION		MARITAL STATUS		PREVIOUS ILLNESS		ALCOHOLIC DRINKING	
TOBACCO SMOKING		DRUGS USED		ALLERGIC REACTIONS		Surgical History		Mental History	
Social History		Physical Examination		Vital Signs		Laboratory Tests		X-ray Examination	
Pathological Findings		Microscopic Examination		Cultures		Immunologic Tests		Other Tests	
Autopsy		Disposition of Body		Burial or Cremation		Funeral Home		Remarks	

RECEIVED
BALTIMORE
MAY 12 1964
DEPT. OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8056 CERTIFICATE OF DEATH

08051

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA.</u> b. COUNTY <u>75X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEDFORD VALLEY R.D. #3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>R.D. #3</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>PERCY</u> Middle <u>HITE</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>6</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1889</u>
9. AGE (In years, last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM A. HITE</u>		14. MOTHER'S MAIDEN NAME <u>MARY M. ZEMBOWER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>205-3016166</u>	
17. INFORMANT <u>LOLA I. HITE, BEDFORD VALLEY, PA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Coronary Artery Disease (History of)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>D.O.A.</u> 19 <u>July 19</u> <u>1958</u> that I last saw the deceased alive on <u>July 19</u> <u>1958</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. <u>OK in this diagnosis & duration</u> ACTUAL SIGNATURE <u>H. H. Hamilton</u> M.D. <u>Millington Md.</u> DATE SIGNED <u>7/6/58</u>			
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		<u>MILLINGTON MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL M.E. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BEDFORD VALLEY, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8049

CERTIFICATE OF DEATH

08052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		c. LENGTH OF STAY IN 1b <u>Short</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & QUEEN ANNE'S</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alonza M. Hubbard</u>			4. DATE OF DEATH Month Day Year <u>July 23 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 2, 1885</u>		9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co., Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Hubbard</u>			14. MOTHER'S MAIDEN NAME <u>Unknown Mary Ellen Morris</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>NONE 220-32-0293</u>		17. INFORMANT <u>ONIDA FRANCES</u> Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure & Pulmonary</u> <u>422.1</u> DUE TO <u>EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>years</u> (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21</u> , 19 <u>58</u> , to <u>July 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>58</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Harry Paul Ross</u>		M.D. <u>141 High St. Chestertown</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>23 July 1958</u>	
PHYSICIAN'S NAME (Type) <u>Harry Paul Ross</u>		High St. Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF HIS OR HER DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08053

8050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Calvert St.		e. STREET ADDRESS 412 Calvert St.	
3. NAME OF DECEASED (Type or print) Samuel Clark Lindsay		4. DATE OF DEATH Month July Day 5 Year 1958	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Lindsay		14. MOTHER'S MAIDEN NAME Harriett Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-8251	
17. INFORMANT Anna Lindsey		412 Calvert St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, generalized 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 months 2 years ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to July , 19 58 , that I last saw the deceased alive on July 4 , 19 58 , and that death occurred at 1:30p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 7-5-58	
PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Janes Cem.	22d. LOCATION (City, town, or county) (State) near Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE Alb...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

Reg. No. 1111

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		M		65		JAN 15 1900		BALTIMORE, MD.	
FATHER		M		65		JAN 15 1900		BALTIMORE, MD.	
MOTHER		F		65		JAN 15 1900		BALTIMORE, MD.	
BORN		M		65		JAN 15 1900		BALTIMORE, MD.	
DIED		M		65		JAN 15 1900		BALTIMORE, MD.	
CAUSE OF DEATH		M		65		JAN 15 1900		BALTIMORE, MD.	
DISEASE		M		65		JAN 15 1900		BALTIMORE, MD.	
SYMPTOMS		M		65		JAN 15 1900		BALTIMORE, MD.	
TREATMENT		M		65		JAN 15 1900		BALTIMORE, MD.	
BURIAL		M		65		JAN 15 1900		BALTIMORE, MD.	
INTERVIEW		M		65		JAN 15 1900		BALTIMORE, MD.	
SIGNATURE		M		65		JAN 15 1900		BALTIMORE, MD.	
DATE		M		65		JAN 15 1900		BALTIMORE, MD.	
PLACE		M		65		JAN 15 1900		BALTIMORE, MD.	
CITY		M		65		JAN 15 1900		BALTIMORE, MD.	
STATE		M		65		JAN 15 1900		BALTIMORE, MD.	
COUNTRY		M		65		JAN 15 1900		BALTIMORE, MD.	
OCCUPATION		M		65		JAN 15 1900		BALTIMORE, MD.	
EDUCATION		M		65		JAN 15 1900		BALTIMORE, MD.	
RELIGION		M		65		JAN 15 1900		BALTIMORE, MD.	
MARRIAGE		M		65		JAN 15 1900		BALTIMORE, MD.	
CHILDREN		M		65		JAN 15 1900		BALTIMORE, MD.	
SIBLINGS		M		65		JAN 15 1900		BALTIMORE, MD.	
PARENTS		M		65		JAN 15 1900		BALTIMORE, MD.	
GRANDPARENTS		M		65		JAN 15 1900		BALTIMORE, MD.	
OTHER RELATIVES		M		65		JAN 15 1900		BALTIMORE, MD.	
FRIENDS		M		65		JAN 15 1900		BALTIMORE, MD.	
NEIGHBORS		M		65		JAN 15 1900		BALTIMORE, MD.	
WITNESSES		M		65		JAN 15 1900		BALTIMORE, MD.	
DOCTOR		M		65		JAN 15 1900		BALTIMORE, MD.	
NURSE		M		65		JAN 15 1900		BALTIMORE, MD.	
CHURCH		M		65		JAN 15 1900		BALTIMORE, MD.	
SCHOOL		M		65		JAN 15 1900		BALTIMORE, MD.	
EMPLOYER		M		65		JAN 15 1900		BALTIMORE, MD.	
OTHER		M		65		JAN 15 1900		BALTIMORE, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8051

CERTIFICATE OF DEATH

08054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Haywood</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Canton</u> <u>70x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kentland Healthcare</u>		d. STREET ADDRESS <u>RFD # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>Shuler</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1958</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Hynson</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Shuler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records - Chestertown Md</u>	
17. INFORMANT <u>Hosp. Records - Chestertown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776x</u> DUE TO (c) <u>776x</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>58</u> , to <u>July 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D. <u>Chestertown</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		DATE SIGNED <u>7-15-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Then please remove carbon papers. Page 3 should be detached for use on the burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8057

CERTIFICATE OF DEATH

08055

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R.D.		c. LENGTH OF STAY IN 1b 3 Mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rudolph F. Middle Tull Last Tull		4. DATE OF DEATH Month July Day 22 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1881
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance underwriter	
11. BIRTHPLACE (State or foreign country) Elkton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Tull		14. MOTHER'S MAIDEN NAME Mary Ellis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 160-09-9738	
17. INFORMANT Address Mrs. Eliz. Coale Tull, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 days 3 years 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to July 22 , 19 58 , that I last saw the deceased alive on July 21 , 19 58 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick		M.D. Chestertown, Md. DATE SIGNED 7-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24/58	
22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JUL 29 '58		24b. REGISTRAR'S SIGNATURE W. L. ...	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		NAME OF PHYSICIAN [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
NAME OF CORONER [Illegible]		SIGNATURE OF CORONER [Illegible]		NAME OF MINISTER [Illegible]	
SIGNATURE OF MINISTER [Illegible]		NAME OF BURIAL PLACE [Illegible]		SIGNATURE OF BURIAL PLACE [Illegible]	
NAME OF FUNERAL HOME [Illegible]		SIGNATURE OF FUNERAL HOME [Illegible]		NAME OF CEMETERY [Illegible]	
SIGNATURE OF CEMETERY [Illegible]		NAME OF STATE DEPARTMENT OF HEALTH [Illegible]		SIGNATURE OF STATE DEPARTMENT OF HEALTH [Illegible]	